Certificate of Need Annual Report of Ambulatory Surgical Centers 2017

Please complete this Report no later than JANUARY 31, 2018.

Name and Address of Facility: *(required)

Email Contact:

Please refer to the instructions: ***Certificate of Need Ambulatory Surgical Center Report 2017 Instructions*** *This will open in a new browser.*

A. REPORTING PERIOD

Required reporting period is January 1, 2017 through December 31, 2017.

1. Was the facility in operation 12 full months at the end of the period? Yes No
2. If NO, please report the number of days in operation. __

B. CLASSIFICATION

1. **NOT FOR PROFIT ( ) FOR PROFIT ( )**
2. a. Owner of facility (company, corporation):

   b. Name of management firm of facility (N/A if management is not provided through contract)

3. a. Is the facility operated as part of a chain, whether for profit or not? Yes No

   b. If YES, please give the name and address of the PARENT organization:

C. UTILIZATION OF SUITES AND SERVICES

1. Total Number of Procedures Performed _____
   (Excluding exploratory/diagnostic endoscopies)
2. Total Number of Exploratory/ Diagnostic Endoscopies Performed _____
3. Total Number of Surgery Suites _____
4. Total Number of Patients _____
   (Patient should be counted only once for multiple procedures performed during same day visit)
5. Total Number of Patients Transferred to Acute Care Hospital During Report Period _____

6. Type of Surgery Performed *(List 12* ***most frequently*** *performed)*

	SURGERY TYPE	CPT CODE NUMBER	NUMBER OF PROCEDURES PERFORMED
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

D. PERSONNEL DATA

		FULL TIME (35 hrs/wk)	PART TIME (<35 hrs/wk)
1.	**Nursing (RN/LPN)**		
2.	**Aides/Technologists**		
3.	**Administration**		
4.	**Other**		
5.	**Total Employees (All Categories)**		

E. FINANCIAL DATA. If actual figures are not available, please estimate (indicate which figures are estimated by checking the box after the amount). Please round to the nearest dollar.

1. a. Total Gross Revenue $

   b. Payroll Expenses $

   c. Non-payroll Expenses $

   d. Total Expenses $

   Please compare financial data with 2016 Annual Report financial data and explain any differences exceeding 10%.

2. Fiscal year ending date / /

3. Facility's average cost and average charge from most recent financial statement:

Average Cost	Average Charge
a.	b.

c. If available, please also submit a copy of the facility's posted charges and costs for each procedure **type** performed. To submit posted charges, use contact information at the end of the report.

4. Procedures and revenue breakdown by payor source:

Payor Source	Number of Procedures	Percent of Operating Revenue
MEDICARE		
MEDICAID		
INSURANCE		
PRIVATE PAY		
UNFUNDED		
OTHERS		
TOTAL		

F. PATIENT ORIGIN DATA

COUNTY	TOTAL	COUNTY	TOTAL	COUNTY	TOTAL
Beaverhead		Hill		Ravalli	
Big Horn		Jefferson		Richland	
Blaine		Judith Basin		Roosevelt	
Broadwater		Lake		Rosebud	
Carbon		Lewis & Clark		Sanders	
Carter		Liberty		Sheridan	
Cascade		Lincoln		Silver Bow	
Chouteau		Madison		Stillwater	
Custer		McCone		Sweet Grass	
Daniels		Meagher		Teton	
Dawson		Mineral		Toole	
Deer Lodge		Missoula		Treasure	
Fallon		Musselshell		Valley	
Fergus		Park		Wheatland	
Flathead		Petroleum		Wibaux	
Gallatin		Phillips		Yellowstone	
Garfield		Pondera		Unknown/In-State	
Glacier		Powder River		Out-of-State	
Golden Valley		Powell			
Granite		Prairie		**TOTAL (Must Equal C.4.)**	

*PLEASE RETURN THIS REPORT NO LATER THAN **JANUARY 31, 2018.***

Date Report Completed / / (MM/DD/YYYY)

Administrator's Name:

If we have questions about any of the responses to this report, whom should we contact?

Name:

Phone Number:

E-Mail:

If you have any questions, please contact the Certificate of Need Program, Department of Public Health & Human Services, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. Telephone (406) 444-9519, Fax (406) 444-1742 or e-mail **consurvey@mt.gov**.

***Please print a copy of the completed report for your records before pressing submit.**

*** I have completed filling out this report.**
This must be checked in order to submit your report.